

WELCOME LETTER (SAMPLE)

Month day, Year]

[Applicant Name]

[Address 1]

[Address 2]

[City, State Zip]

Family Member Number: [Family Member Number]

Dear Applicant:

Thank you for asking about the Healthy Families Medi-Cal Programs. These programs provide low-cost or free health care coverage. There is an application form with this letter that you can use to apply for Healthy Families and Medi-Cal.

What you have to do

1. Fill out the application so we can see if your family meets the Healthy Families or Medi-Cal program rules.
2. Make copies of these important papers:
 - a. Proof of income, such as copies of current pay stubs (within 45 days) or last year's Federal Income Tax Form (1040); and
 - b. Copies of birth certificates or immigration papers; and
 - c. Copies of child support or alimony paid, and child care expense bills.

See page 6 of the application form for a complete list of the papers you will need to send.
3. Mail the application form with the copies of the important papers. Use the envelope that is inside the application form. You do not need a stamp.

Healthy Families Handbook

The Healthy Families Handbook tells how the program works. If you qualify for Healthy Families, you will need to choose a health plan, dental plan and vision plan. You will get your health care from the doctors and other providers in these plans.

If you want to choose these plans now, look at the Healthy Families Handbook for information on the plans, and write down your choices on page A4 of the application. If you do not choose the plans now, we will ask you to choose them later.

What happens next?

When we receive your form, we will look at it and let you know if you get Healthy Families, or if we need to send your application to Medi-Cal.

Questions?

If you have any questions, please call 1-800-880-5305, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free. We can help you fill out the application form over the phone. We can also give you the name and phone number of someone in your area who can help you fill out the application form at no cost to you.

Thank you,

Healthy Families and Medi-Cal Programs

MISSING INFORMATION LETTER (SAMPLE)

Month day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

Recently you sent us a Healthy Families application. Before we can make a decision, you must send your first month premium payment and anything you owe from the past. Here is what you owe:

One Month Premium:	[Child Payable Amount \$\$\$]
Premium Past Due, if any:	[Premium Arrears \$\$\$]
Amount You Paid, if any:	[Amount Paid \$\$\$]
Required Amount to Begin Coverage:	[Balance Due \$\$\$]

What you have to do

Write a check to "Healthy Families Program" for [Balance Due \$\$\$]

1. Write your family member number on the check. Your Family Member Number is [FMN].
2. Mail the check so that we get it by [Month Day, Year]
Healthy Families Program
Attn: Eligibility Review
P. O. Box 138005
Sacramento, CA 95813-8005

What happens next?

We will tell you if your family member can join Healthy Families. You may need to send a new application form if we get your payment after [month day, year].

Questions?

If you have any questions, call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,

Healthy Families Program

CERTIFICATE OF CREDITABLE COVERAGE LETTER (SAMPLE)

Month day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

This letter has information that you may need if someone in your family has a health problem. This letter is a certificate of creditable coverage. Please keep it to show to a new health plan if you join one by [Month Day, Year].

The Healthy Families Program does not provide health coverage any longer to
[person]
[person]
[person].

You may want to get health coverage for your family members from a new health plan. If your family member has a health problem before joining the new plan, this is called “pre-existing condition.” When someone has a pre-existing condition, the new health plan may not cover all necessary health care for a period of time (called a waiting period). If your new health plan has a waiting period, this letter may help you to get health care sooner.

When someone’s health coverage ends, and the person enrolls in (joins) a new health plan within 63 days (not including a waiting period), the new plan must count the time that the person was covered in the old health plan in any pre-existing waiting period.

What you have to do

If your family member has a health problem and joins a new health plan by [Month Day, year]:

1. Make a copy of this letter.
2. Call your new health plan. Ask them “Do you have a waiting period for pre-existing conditions?” If they say “yes,” tell them “My family member has a pre-existing condition. I have a certificate to get credit for the time we were covered before we joined your health plan. Where should I mail this certificate?”
3. Mail the copy of this letter to the address your health plan gives you.

If your new plan says you still have a waiting period

Your new health plan may tell you that you will still have a waiting period, because your family member did not get enough credit for the time that you were in Healthy Families. If your family member was in another health plan before Healthy Families, you may be able to get health coverage from your new plan sooner. Call your old health plan and tell them, "I would like to get a certificate to get credit for the time that I was in your health plan." Then send a copy of the certificate to your new health plan.

Information for your new health plan

This is the information that your new health plan may need:

Client Index Number (CIN)	Enrolled	Disenrolled	Credit Earned	Family Member
[CIN]	[Mo Day, Yr]	[Mo Day, Yr]	[# months]	[Name 1]
[CIN]	[Mo Day, Yr]	[Mo Day, Yr]	[# months]	[Name 2]
[CIN]	[Mo Day, Yr]	[Mo Day, Yr]	[# months]	[Name 3]
[CIN]	[Mo Day, Yr]	[Mo Day, Yr]	[# months]	[Name 4]

Questions?

If you have any questions, please call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,

Healthy Families Program

DISENROLLMENT LETTER (SAMPLE)

Month day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

The Healthy Families Program does not provide health coverage any longer to the following people for the reasons listed below:

[Name 1]	[reason text]
[Name 2]	[reason text]
[Name 3]	[reason text]
[Name 4]	[reason text]

You may have to pay for health, dental, and vision services that these family members get after [Month Day, Year].

[We received your payment and applied it to your past due amount.]

If you think we made a mistake

If you think we made the wrong decision, you can ask us for a review. To ask for a review:

1. Fill out the Program Review form that came with this letter. Tell us why you think your children can still get Healthy Families coverage. You can also send any other papers or information that you would like us to see. We cannot do a review over the phone. Write your Family Member Number on each paper. Your Family Member Number is: [FMN]
2. Mail your Program Review form and any other papers to:
Healthy Families Program
Attn: Review Unit
P. O. Box 138005
Sacramento, CA 95813-8005
Or, you can fax to: 1-866-848-4974. The fax number is free.

We must get your form by [Month Day, Year].

If we receive your Program Review form after this date we cannot review it, and you will have to fill out a new application.

If you want to enroll your child again

If you think your family members meet the program rules and can now get Healthy Families, you can ask us to enroll them again.

1. Fill out the Re-enrollment form that came with this letter.
2. Make copies of these papers:
 - * proof of income, such as copies of pay stubs;
 - * checks or bills that show that you paid child care, child support or alimony.
3. Call 1-866-848-9166 and say: "I want to re-enroll my children in Healthy Families. How much will my premium bill be?"
4. Write a check or money order to Healthy Families Program" for this amount."
5. Mail the Re-enrollment form, copies of your papers, and check to the address above for the Program Review form.

Please send this form to us before [Month Day, Year].

If you sent the Re-enrollment form after this date, you will have to fill out a new application form.

What happens next?

When we get your Re-enrollment form, we will look at the information and we will let you know if your child can get Healthy Families.

Questions?

If you have questions, please call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,

Healthy Families Program